Screening Pap Tests

Overview

In 2004, an estimated 10,520 cases of invasive cervical cancer are expected to occur in the United States, with about 3,900 women dying from this disease. Additionally, cervical cancer mortality increases with age; women ages 65 and older account for nearly 25% of all cervical cancer cases and 41% of cervical cancer deaths in the United States. Among these women over age 65, cervical cancer mortality for African-American women is more than 2.5 times higher than it is for Caucasian women.[6]

However, incidence and mortality rates of cervical cancer are decreasing over time. This trend is largely attributed to cervical screening with the Pap smear/test. Screening Pap smears are laboratory tests consisting of a routine exfoliative cytology test (Papanicolaou test) provided for the purpose of early detection of cervical cancer. It includes a collection of the sample of cells and a physician's interpretation of the test.

A cervical screening detects significant abnormal cell changes that may arise before cancer develops, therefore, if diagnosed and treated early, any abnormal cell changes that may occur over time can be reduced or prevented. The cervical screening examination benefit offered by Medicare can help reduce illness and death associated with abnormal cell changes that may lead to cervical cancer.

Medicare's coverage of the screening Pap test was created as a result of the implementation of the Omnibus Budget Reconciliation Act of 1989 (OBRA 1989). This Act authorized Medicare to begin covering screening Pap tests provided to female beneficiaries on or after July 1, 1990.

Risk Factors

The high risk factors for cervical and vaginal cancer categories are:

Cervical Cancer High Risk Factors

- Early onset of sexual activity (under 16 years of age)
- Multiple sexual partners (five or more in a lifetime)
- History of a sexually transmitted disease [including Human papillomavirus and/or Human Immunodeficiency Virus (HIV) infection]
- Fewer than three negative Pap tests within the previous seven years

Vaginal Cancer High Risk Factors

- DES (diethylstilbestrol)-exposed daughters of women who took DES during pregnancy

Coverage Information

Medicare provides coverage of a screening Pap test for all female beneficiaries when the test is ordered and collected by a doctor of medicine or osteopathy or other authorized practitioner (i.e., a

[6] The National Cancer Institute. July 13, 2004. *Cervical Cancer (PDQ): Screening* [online]. Bethesda, MD: The National Cancer Institute, The National Institutes of Health, The U.S. Department of Health and Human Services, 2004 [cited 1 October 2004]. Available from the World Wide Web: (*www.nci.nih.gov/cancertopics/pdq/screening/cervical/HealthProfessional/page2*).

certified nurse midwife, physician assistant, nurse practitioner, or clinical nurse specialist, who is authorized under State law to perform the examination) under **one** of the following conditions:

Covered once every 12 months:

- There is evidence (on the basis of her medical history or other findings) that the woman is of childbearing age and has had an examination that indicated the presence of cervical or vaginal cancer or other abnormalities during any of the preceding 3 years; **and** at least 11 months have passed following the month that the last covered Pap test was performed.
- There is evidence that the woman is in one of the high risk categories (previously identified) for developing cervical or vaginal cancer, other specified personal history presenting hazards to health **and** at least 11 months have passed following the month that the last covered screening Pap test was performed.

Covered once every 24 months:

- Medicare provides coverage of a screening Pap test for all other female beneficiaries (low risk) every 2 years (i.e., at least 23 months have passed following the month in which the last covered screening Pap test was performed).

NOTE: *The term "woman of childbearing age" means a woman who is premenopausal, and has been determined by a physician, or qualified practitioner, to be of childbearing age, based on her medical history or other findings.*

Coverage for a Pap test is provided as a Medicare Part B benefit. The coinsurance or copayment applies for the Pap test collection; however, there is no Medicare Part B deductible for test collection. The beneficiary will pay nothing for the Pap laboratory test (there is no deductible and no coinsurance or copayment for the Pap laboratory test).

Coding and Diagnosis Information

Procedure Codes and Descriptors

The following are Healthcare Common Procedure Coding System (HCPCS) codes for reporting screening Pap tests. Code selection depends on the reason for performing the test, the methods of specimen preparation and evaluation, and the reporting system used. Medicare-covered Pap tests are reported using the HCPCS codes listed in Table 1.

HCPCS Codes	HCPCS Code Descriptors
G0123	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision
G0143	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and rescreening by cytotechnologist under physician supervision
G0144	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system under physician supervision
G0145	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system and manual rescreening under physician supervision
G0147	Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision
G0148	Screening cytopathology smears, cervical or vaginal, performed by automated system with manual rescreening
P3000	Screening Papanicolaou smear, cervical or vaginal, up to three smears, by technician under physician supervision

Table 1 - HCPCS Codes for Screening Pap Tests

There are three HCPCS codes for reporting the physician's interpretation of screening Pap tests. Code selection depends on the reason for performing the test, the methods of specimen preparation and evaluation, and the reporting system used.

The following HCPCS codes are used to report the physician's interpretation of screening Pap tests:

HCPCS Codes	HCPCS Code Descriptors
G0124	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician
G0141	Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician
P3001	Screening Papanicolaou smear, cervical or vaginal, up to three smears, requiring interpretation by physician

Table 2 - HCPCS Codes for Physician's Interpretation of Screening Pap Tests

The following code must be used when the physician obtains, prepares, conveys the test, and sends the specimen to a laboratory:

HCPCS Code	HCPCS Code Descriptor
Q0091	Screening papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory

Table 3 - HCPCS Codes for Laboratory Specimen of Pap Tests

Diagnosis Requirements

When a claim is filed for a screening Pap test, one of the screening ("V") diagnosis codes listed in Table 4 must be used. Code selection depends on whether the beneficiary is classified as low risk or high risk. This diagnosis code, along with other applicable diagnosis codes, must also be reported. Failure to report the V76.2, V76.47, V76.49, or V15.89 diagnosis code will result in denial of the claim.

ICD-9-CM Codes	ICD-9-CM Code Descriptors
V76.2	Special screening for malignant neoplasms; Cervix; Routine cervical Papanicolaou smear. *Excludes: that as part of a general gynecological examination (V72.3)*
V76.47	Special screening for malignant neoplasms; Other sites; Vagina; Vaginal pap smear status-post hysterectomy for non-malignant condition. Use additional code to identify acquired absence of uterus (V45.77). *Excludes: vaginal pap-smear status-post hysterectomy for malignant condition (V67.01)*
V76.49	Special screening for malignant neoplasms; Other sites.
V15.89	Other personal history presenting hazards to health; Other specified personal history presenting hazards to health; Other.

Table 4 - Screening Pap Test Diagnosis Codes

Billing Requirements

Billing and Coding Requirements When Submitting to Carriers

When submitting claims to Carriers, the appropriate HCPCS code (Table 1) and the corresponding diagnosis code must be reported on Form CMS-1500 (or the HIPAA 837 Professional electronic claim format).

Billing and Coding Requirements When Submitting to Fiscal Intermediaries (FIs)

Screening Pap test services may be billed to an FI by the technical component category, which is defined as services rendered outside the scope of the physician's interpretation of the results of an examination, or the professional component category, which is defined as a physician's interpretation of the results of an examination.

When submitting claims to FIs, the appropriate HCPCS code (Tables 1-3), the appropriate revenue code, and the corresponding diagnosis code must be reported on Form CMS-1450 (or the HIPAA 837 Institutional electronic claim format).

Types of Bills for FIs

As required by CMS, there are five specific bill types that are applicable for screening Pap tests [and two additional bill types in limited situations within Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)]. The applicable FI claim Types of Bills (TOBs) and associated revenue codes for Pap test screening services are:

Facility Type	Type of Bill	Revenue Codes
Hospital Outpatient	13X, 14X	0311
Skilled Nursing Facility (SNF) Inpatient Part B	22X	
SNF Outpatient	23X	
Critical Access Hospital (CAH)	85X	
Rural Health Clinic (RHC)	See Additional Billing Instructions for RHCs and FQHCs to follow.	
Federally Qualified Health Center (FQHC)		

Table 5 - Facility Types, Types of Bills, and Revenue Codes for Pap Test Screening Services

NOTE: Effective April 1, 2005, RHCs and FQHCs will no longer have to report additional line items when billing for preventive and screening services on TOBs 71X and 73X. Also, CMS is eliminating the special HCPCS coding for independent and hospital-based FQHCs billed on TOB 73X. Except for telehealth originating site facility fees reported using revenue code 0780, all charges for RHC/FQHC services must be reported on the revenue code line for the encounter, 052X, or 0900/0910. For further instructions, see CR 3487, transmittal 371, dated November 19, 2004, Updated Billing Instructions for RHCs and FQHCs.

NOTE: Revenue code 0923 must be used for billing code Q0091 (Table 3).

NOTE: Critical Access Hospitals (CAHs) electing method II report services under revenue codes 096X, 097X, or 098X in addition to reporting the technical component.

Each FI may choose to accept other bill types for the technical component of the Pap test. If a provider would like to bill using a different bill type, the provider must contact the FI to determine if the particular bill type is allowed.

Additional Billing Instructions for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

RHCs and FQHCs must follow these additional billing instructions to ensure that proper payment is made for services.

There are specific billing and coding requirements for both the technical component and the professional component when a screening pelvic examination is furnished in an RHC or a FQHC. The technical component is defined as services rendered outside the scope of the physician's interpretation of the results of an examination. The professional component is defined as the physician's interpretation of the results of an examination.

Coding Tip

A screening Pap test and a screening pelvic examination can be performed during the same encounter. When this happens, both procedure codes should be shown as separate line items on the claim.

Billing Requirements for the Technical Component for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

The technical component of a screening Pap test is outside the scope of the RHC/FQHC benefit. If the technical component of this service is furnished within an independent RHC or freestanding FQHC, the provider of that technical service bills the Carrier on Form CMS-1500 (or the HIPAA 837 Professional electronic claim format) under the provider's practitioner number.

If the technical component of a screening Pap test is furnished within a provider-based RHC or FQHC, the base provider bills for the technical portion of the test under their own provider number on TOB 13X, 14X, 22X, 23X, or 85X, as appropriate, and are required to use revenue code 0311.

If the RHC/FQHC is independent, the practitioner can bill the Carrier under their practitioner number.

NOTE: Independent RHCs and Freestanding FQHCs are freestanding practices that are not part of a hospital, Skilled Nursing Facility (SNF) or Home Health Agency (HHA). Provider-based RHCs and FQHCs are integral and subordinate parts of hospitals, SNFs, or HHAs, and under common licensure, governance, and professional supervision.

Billing Requirements for the Professional Component for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

The professional component of a screening Pap test furnished within an RHC/FQHC by a physician or qualified non-physician is considered an RHC/FQHC service. RHCs bill on TOB 71X with revenue code 0521 (in rare cases 0522) and FQHCs bill on TOB 73 with revenue code 0520.

In general the RHC/FQHC bills for the visit where the Pap test was obtained and are reimbursed under the all-inclusive rate for the entire visit.

Reimbursement Information

General Information

Coverage for the Pap test is provided as a Medicare Part B benefit. The Medicare Part B deductible for screening Pap tests and services paid for under the Medicare Physician Fee Schedule does not apply. The coinsurance and deductible do not apply for the laboratory Pap test.

Additional information about the MPFS can be found at: *www.cms.hhs.gov/physicians/pfs/* on the CMS website.

Additional information about the Clinical Laboratory Fee Schedule can be found at: *www.cms.hhs.gov/providers/pufdownload/clfcrst.asp* on the CMS website.

Additional information about OPPS can be found at: *www.cms.hhs.gov/providers/hopps/* on the CMS website.

Reimbursement of Claims by Carriers

Reimbursement for screening Pap test services is based on the Clinical Laboratory Fee Schedule or the Medicare Physician Fee Schedule (MPFS).

- The Medicare Part B deductible and the coinsurance or copayment do not apply for Pap test services paid under the Clinical Laboratory Fee Schedule (Table 1) when billed to the Carrier.
- The Part B deductible is also waived for Pap test services paid under the MPFS (Table 2 and Table 3), however coinsurance or copayment applies when billed to the Carrier.

NOTE: The same physician may report a covered Evaluation and Management (E/M) visit and code Q0091 for the same date of service if the E/M visit is for a separately identifiable service. In this case, the modifier -25 must be reported with the E/M service and the medical records must clearly document the E/M service reported. Both procedure codes are to be shown as separate line items on the claim. These services can also be performed separately during separate office visits.

Reimbursement of Claims by Fiscal Intermediaries (FIs)

Reimbursement for most screening Pap test services is based on the Clinical Laboratory Fee Schedule or the MPFS.

The Medicare Part B deductible and the coinsurance or copayment do not apply for Pap test services paid under the Clinical Laboratory Fee Schedule (Table 1) when billed to the FI [with the exception of code Q0091 (Table 3)].

The Medicare Part B deductible is also waived for Pap test services paid under the MPFS (Table 2), however coinsurance or copayment applies when billed to the FI.

For code Q0091, the Medicare Part B deductible is waived; however, coinsurance or copayment does apply when billed to the FI. Payment for code Q0091 in a hospital outpatient department is based on the Outpatient Prospective Payment System (OPPS). A SNF is paid based on the MPFS. A CAH is paid on a reasonable cost basis. RHC/FQHC payment for this code is based on the all-inclusive rate for the professional component.

Reasons for Claim Denial

Following are examples of situations when Medicare may deny coverage of screening Pap tests:

To obtain Carrier and FI contact information please visit *www.cms.hhs.gov/contacts/incardir.asp* on the CMS website.

- The beneficiary who is not at high risk has received a covered Pap test within the past 2 years.
- The beneficiary who is at high risk has received a covered Pap test during the past year.

Providers may find specific payment decision information on the Remittance Advice (RA). The RA will include Health Care Claim Adjustment Reason Codes and RA Remark Codes to provide additional information on payment adjustments. The most current listing of these codes can be found at *www.wpc-edi.com/Codes* on the Web. Additional information about claims can be obtained from the Carrier or FI.

Written Advance Beneficiary Notice (ABN) Requirements

An Advance Beneficiary Notice (ABN) is a written notice that a provider or supplier gives to a Medicare beneficiary. The purpose of the ABN is to inform a beneficiary, before he or she receives specified items or services that otherwise might be paid for by Medicare, that Medicare probably will not pay on that particular occasion. The ABN allows the beneficiary to make an informed consumer decision whether or not to receive the items or services for which he or she may have to pay out of pocket or through other insurance.

Beneficiary Notices Initiative (BNI)

BNI is an agency objective to improve agency-to-beneficiary communications to further beneficiary education and health promotion, and to facilitate access to and exercise of individual rights and protections. For more information please visit *www.cms.hhs.gov/medicare/bni* on the CMS website.

Frequently, there is confusion regarding whether an ABN can be used to shift liability to a beneficiary for the cost of non-covered items or services. In making this decision, the provider/supplier first must determine whether the item or service meets the definition of the Medicare-covered benefit. If the item or service does not meet the definitional requirements for the Medicare-covered benefit, then the item or service will never be covered by Medicare. As a result, the beneficiary will always be liable for the cost of the item or service, and an ABN is not needed to shift liability to the beneficiary.

If the item or service meets the definition of the Medicare-covered benefit, Medicare still may not pay for the item or service if the item or service was “not reasonable and necessary” for the beneficiary on the occasion in question or if the item or service exceeds the frequency limitation for the particular benefit or falls outside the applicable time frame for receipt of the covered benefit. In these instances, an ABN may be used to shift liability for the cost of the item or service to the beneficiary. If an ABN is not issued to the beneficiary, the provider/supplier may be held liable for the cost of the item or service unless the provider/supplier is able to demonstrate that they did not know and could not reasonably have been expected to know that Medicare would not pay for the item or service.

Screening Pap Tests

Resource Materials

Physician Information Resource for Medicare Website
This site contains physician-specific information, including updates to policies (such as MPFS), regulations, coding and coverage information, program integrity information, and other valuable resources.
www.cms.hhs.gov/physicians

Medicare Fee-For-Service Providers Website
This site contains detailed provider-specific information, including information about the Clinical Laboratory Fee Schedule and OPPS.
www.cms.hhs.gov/providers

Medicare Learning Network
The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare providers. For additional information visit the Medicare Learning Network's Medlearn web page at *www.cms.hhs.gov/medlearn* on the CMS website.

Preventive Services Educational Resource Web Guide
www.cms.hhs.gov/medlearn/preventiveservices.asp

The National Cancer Institute. July 13, 2004. *Cervical Cancer (PDQ): Screening* [online]. Bethesda, MD: The National Cancer Institute, The National Institutes of Health, The United States Department of Health and Human Services, 2004 [cited 1 October 2004].
www.nci.nih.gov/cancertopics/pdq/screening/cervical/HealthProfessional/page2

National Cancer Institute
www.nci.nih.gov

Beneficiary Notices Initiative Website
www.cms.hhs.gov/medicare/bni

Carrier and FI Contact Information
www.cms.hhs.gov/contacts/incardir.asp

National Correct Coding Initiative Edits Website
www.cms.hhs.gov/physicians/cciedits

Washington Publishing Company (WPC) Code Lists
WPC assists in the maintenance and distribution of HIPAA-related code lists that are external to the X12 family of standards.
www.wpc-edi.com/Codes

Beneficiary-related resources can be found in Reference D of this Guide.

Notes